Improving urgent stroke services in Kent and Medway

A consultation by the 10 NHS Clinical Commissioning Groups of: Ashford, Bexley, Canterbury and Coastal, Dartford Gravesham and Swanley, High Weald Lewes Havens, Medway, South Kent Coast, Swale, Thanet, and West Kent.

The consultation is open for 10 weeks from **2 February 2018 to 13 April 2018**.

This document is a plain text, large print version of the main consultation document. If you or someone you know needs this document in another language or format please contact us at **km.stroke@nhs.net.**

The public consultation is on proposals to improve hospital-based urgent stroke services for people in Kent and Medway, and surrounding areas. Background information, other alternative formats and a response survey are available at www.kentandmedway.nhs.uk/stroke

Reducing your risk of stroke

This consultation is about the services that help people who do have a stroke. But there are things we can all do to reduce the risk of having a stroke. Eating a healthy diet, exercising regularly, and avoiding smoking and too much alcohol will help prevent strokes.

Diet
An unhealthy diet can increase your chances of having a stroke because it may lead to increased blood pressure and cholesterol levels.

Exercise
Combining a healthy diet with regular exercise is the best way to maintain a healthy weight. Regular exercise can also help lower your cholesterol and keep your blood pressure healthy.

Smoking
Being a smoker significantly increases your risk of having a stroke because it narrows your arteries and makes your blood more likely to clot.

Alcohol
Too much alcohol can lead to high blood pressure and trigger an irregular heartbeat (atrial fibrillation), both of which can increase your risk of having a stroke.

If you have been diagnosed with a condition known to increase your risk of stroke, ensuring the condition is well controlled is also important in helping prevent strokes. Find out more at www.nhs.uk/conditions/stroke/prevention/ or search NHS stroke prevention.

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1. Foreword

We know that all the staff in our stroke services are working extremely hard to provide the best possible care that they can. But we also know that things would be better, for both patients and staff, if we developed our stroke services further.

Our goal is to make sure stroke services across the whole of Kent and Medway meet the latest national standards and best practice recommendations. We do not always achieve this now. These new ways of working have been introduced in other parts of the country and are bringing significant benefits. We do not want Kent and Medway to be left behind. We want stroke patients in every part of Kent and Medway, and those in

neighbouring communities who may use Kent and Medway services, to get consistently excellent care.

We started reviewing our stroke services in late 2014. It has been a long and detailed process involving a wide range of clinicians, patients and the wider public. There is a strong view that stroke care could and should be improved. In many cases people have urged us to make changes as quickly as we can.

The changes we are proposing are significant. They would affect every hospital in our area, residents in every part of Kent and Medway, and some beyond our boundaries. They would take time to build and would need to be fit for purpose for many years to come. So it is essential that we get them right.

This consultation is another opportunity to make your voice heard and help us design the best stroke services. We encourage everyone to respond, whether you have been involved in the earlier work or not; whether you work in the local NHS or are a resident; whether you have firsthand experience of stroke or not. All views are important to us.

This document sets out the reasons why we believe we need to improve specialist stroke services in Kent and Medway and bring them together onto three sites. We have looked at a wide range of issues from travel times through to staffing issues and how long it would take to establish the new services at different hospitals across the area.

We recognise that people have concerns when hospital services change, but we strongly believe that change is needed. These proposals would represent a

major investment in stroke services and a commitment to making consistently high quality care available for all stroke patients, regardless of where you live or when a stroke happens. There is more background information on the consultation web pages and we encourage you to have a look at this.

After the consultation closes and all your comments have been considered alongside a range of other evidence and information, we will move forward and make a decision on the future shape of urgent stroke services in Kent and Medway. It would take some time to make any changes and we are committed to continuing to engage and involve a wide range of people on an on-going basis.

Signed by: the independent Chair of the Joint Committee of Clinical Commissioning Groups; the Clinical Chairs of the 10 Clinical Commissioning Groups; and the Chief Executive of the Kent and Medway Sustainability and Transformation Partnership:

Dr Mike Gill, Chair of the Joint Committee of Clinical Commissioning Groups

Dr Navin Kumta, Clinical Chair, NHS Ashford CCG

Dr Sid Deshmukh, Clinical Chair, NHS Bexley CCG

Dr Simon Dunn, Clinical Chair, NHS Canterbury and Coastal CCG

Dr Sarah MacDermott, Deputy Clinical Chair, NHS Dartford Gravesham and Swanley CCG

Dr Elizabeth Gill, Clinical Chair, NHS High Weald Lewes Havens CCG

Dr Peter Green, Clinical Chair, NHS Medway CCG

Dr Jonathan Bryant, Clinical Chair, NHS South Kent Coast CCG

Dr Fiona Armstrong, Clinical Chair, NHS Swale CCG

Dr Tony Martin, Clinical Chair, NHS Thanet CCG

Dr Bob Bowes, Clinical Chair, NHS West Kent CCG

Glenn Douglas, Chief Executive, Kent and Medway Sustainability and Transformation Partnership

2. About this consultation

Stroke services can be separated into three areas: prevention; urgent care during a stroke; and rehabilitation. This consultation document is focused on changes to the urgent stroke services provided in hospitals across Kent and Medway.

The consultation is being run jointly by the 8 clinical commissioning groups in Kent and Medway (Ashford, Canterbury and Coastal, Dartford Gravesham and Swanley, Medway, South Kent Coast, Swale, Thanet, and West Kent), along with NHS Bexley Clinical Commissioning Group in London, and NHS High Weald Lewes Havens Clinical Commissioning Group in East Sussex.

This consultation document includes information on:

- What services are currently like and why we believe they need to change
- Our ambition for the future and best practice guidelines for modern stroke services
- The proposals we are consulting on and what they might mean for you
- How to give us your views and what the next steps will be.

Before completing our questionnaire or sending your comments you may want to look at the detailed supporting information on our website www.kentandmedway.nhs.uk/stroke including:

- The pre-consultation business case (PCBC)
- Engagement activity report
- Travel time modelling
- Options evaluation process
- Integrated Impact Assessment.

Improving stroke services is part of a wider programme across Kent and Medway involving all the local NHS organisations, Kent County Council and Medway Council. We are looking at what needs to be done differently to bring about better health and wellbeing, better standards of care, and better use of staff, funds and other resources.

The changes to hospital-based stroke services are being developed alongside and in alignment with other work on improving hospital services, developing more local care outside of hospitals, and improving mental health and social care. We believe it is imperative that we move forward with a decision on improvements to stroke services, but we will continue to align stroke improvements to our wider sustainability and transformation partnership programme.

You can find out more about our sustainability and transformation partnership and the other projects at www.kentandmedway.nhs.uk.

If you would like to find out more about stroke, the symptoms and what to do if you or someone you know has a stroke visit www.nhs.uk/actfast.

Summary

This document outlines proposals to improve hospital-based urgent stroke services for people in Kent and Medway, and surrounding areas of south east London and East Sussex.

Our proposal is to establish hyper acute stroke units operating 24 hours a day, 7 days a week, to care for all stroke patients seen in Kent and Medway.

Each unit would also have alongside it:

- an acute stroke unit where people may go after the initial 72 hours for further care until they are ready to be discharged
- a transient ischaemic attack clinic (TIAs are also known as “mini strokes” and can be an indication that a stroke may follow).

We are consulting on the proposal to establish hyper acute stroke units; whether 3 is the right number; and 5 potential options for their location.

The new services would ensure all residents get consistently high quality hospital- based stroke care regardless of where they live or what time of day or night a stroke occurs. However, urgent stroke services would not be available at other hospitals in Kent and Medway.

The proposals are focused on improving care and outcomes for people who have a stroke – meaning fewer deaths and less disability. They are not aimed at saving money. To make these changes we would be investing up to £40 million in hospitals and recruiting more staff.

About stroke and best practice treatment

Stroke is a serious, life-threatening medical condition that happens when the blood supply to the brain is cut off, either by a bleed or clot in a blood vessel. There are around 3,000 patients a year who have a stroke for whom a Kent and Medway hospital is their nearest. How well people recover is affected by the speed and quality of treatment.

National best practice is to have dedicated hyper acute stroke units that are staffed by teams of stroke specialists around the clock and have consultants on the unit seven days a week, with access to all the equipment they need for diagnosing and treating stroke patients. Patients should be taken to these units directly to receive specialist stroke care as soon as possible after having a stroke. Units should see a minimum of 500 patients a year to make sure staff maintain and develop their specialist skills. Similar changes have already been implemented in other parts of England and have proven to save lives and reduce disability

Local challenges and the improvements needed

We know that hospital staff in Kent and Medway provide the best service they can for people who have a stroke. However, despite their best efforts, the way stroke services are currently organised, and a shortage of specialist staff,

means the majority of our hospital stroke services do not consistently meet national standards for clinical quality. A significant reason for this is because specialist resources are stretched too thinly across the current hospital sites.

- We have only 1/3 of the stroke consultants needed to deliver a best practice service in all hospitals

- 24 hour 7 day access is not consistently available for consultants, brain scans and clot busting drugs

- 1 in 3 stroke patients are not getting brain scans in the recommended time after arriving at hospital

- Only 1 unit sees enough stroke patients for staff to maintain and develop their expertise (recommended minimum of 500 stroke patients per year)

- 1/2 of appropriate patients are not getting clot busting drugs in the recommended time after arriving at hospital

The primary aim of our stroke review is to ensure that anybody who has a stroke, day or night, anywhere across Kent and Medway, and in our border areas in south east London and East Sussex, has the best chances of survival and recovery.

We want all our urgent stroke services to meet the national quality standards and offer patients the best care. Looking ahead, we want stroke services in Kent and Medway to be forward thinking and at the forefront of evidence-

based care, with the best staff able to offer the latest developments in stroke treatment.

To achieve our vision, we must get the basics right and organise stroke services across Kent and Medway differently to how they are today.

Summary of review to date

This has been a detailed review which began in late 2014. Clinicians from stroke services, general practice and the ambulance service have led the review and have developed the proposals in this document. Throughout the process we have engaged with patients, the public, staff and other stakeholders to help shape our plans.

Information on specific engagement activity that has taken place is set out in section 5 of this document and in supporting documents on our website.

The options for consultation

We are consulting on the proposal to establish hyper acute stroke units; whether 3 is the right number; and 5 potential options for their location. There has been a detailed process to consider options for the future shape of hospital-based urgent stroke services before proposing 3 sites and possible locations.

Over the course of the review we looked at:

- a long list that considered different numbers of hyper acute stroke units
- a medium list of possible 3-site options

- the shortlist of 3-site options now being consulted on.

Our shortlist has 5 potential options for where 3 hyper acute stroke units could be located in the future:

Option A - Darent Valley Hospital, Medway Maritime Hospital, and William Harvey Hospital

Option B - Darent Valley Hospital, Maidstone Hospital, and William Harvey Hospital

Option C - Maidstone Hospital, Medway Maritime Hospital, and William Harvey Hospital

Option D - Tunbridge Wells Hospital, Medway Maritime Hospital, and William Harvey Hospital

Option E - Darent Valley Hospital, Tunbridge Wells Hospital and William Harvey Hospital

The order is not a ranking and we are not identifying a preferred option until we have fully and carefully considered all the evidence and data available to us, including the views and feedback gathered via this public consultation. There is information in section 6 about why some hospitals are not included in any of the options.

To develop the options our calculations of travel times and how many stroke patients each unit would see have also included people living in areas outside Kent and Medway where one of our proposed hyper acute stroke units may become their closest specialist stroke service, depending on where they live.

This would include:

- **Bexley residents** – a hyper acute stroke unit at Darent Valley Hospital may become their nearest, depending on where they live.

- **High Weald Lewes Havens residents** – a hyper acute stroke unit at Tunbridge Wells Hospital may become their nearest, depending on where they live.

Other residents in neighbouring communities may access Kent and Medway hospitals but are more likely to be taken by ambulance to hyper acute stroke units in Eastbourne District General Hospital, Royal Sussex County Hospital in Brighton, East Surrey Hospital in Redhill and the Princess Royal University Hospital in Orpington, and we have taken account of this in our modelling as we have designed our proposals.

The benefits of the proposed changes

The main benefits would be:

- all stroke patients using Kent and Medway services receiving consistently high quality care regardless of where they live or when their stroke occurs (i.e. reducing the variable quality of care currently provided)

- more patients getting brain scans and, if needed, clot busting drugs within the recommended time

- a reduction in deaths from stroke

- fewer people living with long-term disability following a stroke

- fewer people losing their independence and being admitted to nursing/care homes following a stroke

- shorter stays in hospital

- clinics for transient ischaemic attacks (TIA) or “mini strokes” would be consistently available 7 days a week

- improved experiences for patients and their family, friends and carers from being treated in a specialist unit with services available 24 hours a day, 7 days a week

- improved experiences for staff from improvements in patient care, improved team and multi-disciplinary working, and increased opportunities to maintain and build their specialist skills.

In section 6 of this document we also outline potential disadvantages of the proposed changes and concerns which have been raised by patients, the

public, staff and other stakeholders during the earlier stages of our review. These include issues around whether 3 units is the right number; travel times; the impact on hospitals that would no longer have stroke services; and the recruitment and retention of stroke staff.

We hope the information provided on these issues will help you to form your own views in order to respond to the consultation.

How to comment

This consultation runs from 2 February 2018 to 13 April 2018. There are specific questions at the end of this document which we would like your views on, as well as any other comments you have about the proposals.

Comments can be sent back by freepost or online and by phone. We will also have a number of public meetings where you can discuss these proposals with members of the review group. Full details of how you can give your views are set out in section 7 of this document and meetings will be listed on our website www.kentandmedway.nhs.uk/stroke.

3. About stroke and best practice treatment

What is a stroke?

Stroke is a serious, life-threatening medical condition that happens when the blood supply to the brain is cut off by either a blood clot or a bleed in one of the blood vessels, causing damage to the brain tissue.

The effects of a stroke depend on which part of the brain is injured and how severely it is affected. We know that the care given in the first 72 hours after a stroke has the greatest impact on reducing long-term damage and disability.

The type of treatment needed depends on the type of stroke, and whether it is caused by a bleed or a clot, which can only be determined by a brain scan and expert diagnosis. But everyone who has a stroke benefits from receiving care in a hospital with specialist stroke services including immediate intensive rehabilitation support in the hospital and further support in the community if needed.

A transient ischaemic attack (TIA) or “mini stroke” is caused by a temporary disruption in the blood supply to part of the brain. This results in a lack of oxygen to the brain and can cause sudden symptoms similar to a stroke, such as speech and visual disturbance, and numbness or weakness in the face, arms and legs. However, a TIA doesn’t last as long as a stroke. The effects often only last for a few minutes or hours and fully disappear within 24 hours.

What is the impact of stroke?

Stroke is a major health problem in the UK. It is the third biggest cause of death in the UK and the largest single cause of severe disability. There are around 3,000 stroke patients a year for whom a Kent and Medway hospital is their nearest.

Stroke can affect people of any age or background, although some people are more at risk of a stroke, including older people and people with Indian, Bangladeshi and Pakistani heritage. Smoking, obesity, diabetes and high blood pressure are also major factors that increase the risk of having a stroke.

However, stroke is a preventable and treatable disease. Fewer people have been dying of stroke since the late 1960s. This is in part due to a better understanding of the causes of stroke, and how to prevent them. It is also because of the development of specialist stroke units and the use of clot-busting drugs, called thrombolysis. Making sure we have specialist services consistently available in Kent and Medway is a key aim of the proposals we are consulting on.

National best practice for stroke services

National best practice guidelines and standards, based on the latest clinical evidence and research, tell us what treatments and ways of working give patients the best chance of survival and a good recovery from a stroke.

This evidence tells us that patients get the best outcomes when they are admitted quickly to a specialist stroke unit and cared for there for the first 72 hours following a stroke. These units are called hyper acute stroke units or HASUs.

National standards and best practice guidance describe a hyper acute stroke unit as:

- Run by a multi-disciplinary team of specialist stroke staff (i.e. a team with a mix of professionals such as consultant doctors, radiologists, occupational therapists and physiotherapists, specialist stroke nurses, speech therapists, dietitians, orthoptists).

- Treating at least 500 confirmed stroke patients each year. This is to ensure the staff see enough patients to maintain their competency levels and build their expertise.

- Open 24 hours a day, 7 days a week with access at all times to brain scanning equipment and clot-busting drugs (thrombolysis) and the specialist cover to review scans and provide thrombolysis.

- Having consultant ward rounds at least once a day 7 days a week

- Admitting people directly onto the unit avoiding waits in A&E

- Offering patients and carers high quality information and support.

After the first 72 hours, or once they are stable, patients should then be cared for on an acute stroke unit until they can be discharged with a comprehensive plan for ongoing rehabilitation.

Stroke patients should receive at least 90% of their inpatient care in a specialist stroke service (hyper acute stroke unit and acute stroke unit) rather than on general hospital wards.

An urgent care stroke service should also regularly and routinely evaluate and measure what it does, publish data about how it is performing and constantly look for improvements.

Learning from other parts of the country

We know from other parts of the country that setting up hyper acute stroke units does improve the quality and experience of care, and improve patient outcomes.

In London there have been significant reductions in death and disability caused by stroke since the introduction of hyper acute units, as well as shorter hospital stays. Approximately 100 lives a year have been saved since changes to the way stroke services are organised in London were introduced. Manchester has implemented similar changes with positive results, particularly in reducing the number of days patients need to stay in hospital recovering from a stroke. And across the country the NHS is either in the process of implementing or considering similar changes to consolidate stroke care into hyper acute stroke units. We are continuing to monitor and learn from others who are further ahead with this work.

4. Local challenges and the improvements needed

We know that we can do more to save more lives, limit the damage caused by a stroke and help people recover more quickly. To do this we would need to change how stroke services are organised across hospital sites. Doing this would help us to meet the needs of local people and deliver evidenced-based high quality care to national standards.

How stroke services operate now in Kent and Medway

In 2016/17 around 3,000 patients were treated for stroke in Kent and Medway hospitals. This includes approximately 250 patients from outside our area, but for whom our hospitals offer the closest stroke services.

Currently, hospital stroke services are provided across 6 of the 7 acute hospital sites in Kent and Medway, but we do not have any 24 hours a day, 7 days a week, hyper acute stroke units. General hospital-based stroke services are currently provided at:

Darent Valley Hospital, Dartford

Maidstone Hospital, Maidstone

Medway Maritime Hospital, Gillingham

Queen Elizabeth, the Queen Mother Hospital, Margate

Tunbridge Wells Hospital, Pembury

William Harvey Hospital, Ashford

Until April 2017 stroke services were also provided at Kent and Canterbury Hospital. This stroke service has been stopped temporarily due to withdrawal of training doctors by Health Education England which meant services could not be provided safely.

People in Kent and Medway also use stroke services provided by the Princess Royal University Hospital in Orpington (part of Kings College Hospital NHS Foundation Trust) and Eastbourne Hospital (part of East Sussex Healthcare NHS Trust). Some people from south London and East Sussex also use Kent and Medway hospitals.

The current challenges with stroke services – our case for change

We know that hospital staff in Kent and Medway provide the best service they can for people who have a stroke. However, despite their best efforts, the way stroke services are organised, along with a shortage of specialist staff, means the majority of our local hospital stroke services do not consistently meet national standards for clinical quality. A significant reason for this is because specialist resources are stretched too thinly across the current hospital sites.

Key areas where Kent and Medway stroke services are failing against national standards:

- We are not able to run 24 hours a day, 7 days a week, hyper acute stroke units which have scanning equipment, clot-busting drugs and stroke consultants available on the units every day. There are acute stroke services, but we cannot consistently provide specialist cover 7 days a week.

- We have less than a third of the stroke consultants we need to run 24/7 services on all our existing hospital sites. Staffing levels for other clinical roles (such as stroke nurses) are also below the recommended level and we would need to fill 51 additional full time non-consultant roles for all sites.

- Only 1 hospital (Medway) currently sees the recommended minimum number (500 per year) of stroke patients for staff to maintain their skills and build expertise.

- Over a third of stroke patients using Kent and Medway hospitals are not getting a brain imaging scan within the recommended one hour of admission to hospital. These scans are essential to determine whether the stroke has been caused by a bleed or a blockage and to indicate the right treatment.

- Following a scan, only a half of Kent and Medway's stroke patients who need clot busting drugs (thrombolysis) get them within the recommended time.

What does this mean for you?

When looking at Kent and Medway as a whole, the challenges facing hospital stroke services mean if you, or a loved one, have a stroke, you may not always have access to the most specialist stroke staff around the clock, particularly at nights and weekends. This could lead to:

- a greater risk of death
- a greater risk of long-term disability and therefore poorer long-term quality of life
- increased likelihood of losing independence and admission to a residential or nursing home.

Our vision for stroke services across Kent and Medway

The primary aim of our stroke review is to ensure that anybody who has a stroke, day or night, anywhere across Kent and Medway, and in our border

areas in south east London and East Sussex, has the best chances of survival and recovery with a return to living an independent fulfilling life.

Looking ahead, we want stroke services in Kent and Medway to be forward thinking and at the forefront of evidence based care. We want to be able to offer local people the latest developments in stroke treatment. This includes potentially being able to offer mechanical thrombectomy (a complex procedure to remove blood clots in the brain). This is new to the NHS and currently the few Kent and Medway residents who are suitable for treatment are transferred to highly specialised units in London. It is our ambition to provide it locally in the future from one of the proposed new hyper acute stroke units.

To achieve our vision, we must get the basics right and organise stroke services across Kent and Medway differently to how they are today. Currently, none of our stroke units in Kent and Medway meet the best practice guidelines and standards for hyper acute stroke units. This is not good enough. Patients are not getting the care and treatment they need. By improving patient care by introducing hyper acute stroke units we can save lives and reduce long-term disability.

We want all our urgent stroke services to meet the national quality standards and offer patients the best care. To do this we need to reorganise services to create hyper acute stroke units that:

- run a full service 7 days a week, 24 hours a day

- scan patients as soon as possible and within 1 hour of arrival and give clot busting drugs, if needed, within 2 hours of calling the ambulance

- have 7 day a week cover from stroke consultants, specialist stroke nurses and stroke therapists

- have consultant ward rounds at least once a day 7 days a week

- admit patients directly

- see more than 500 confirmed stroke patients a year.

In addition, we want to make sure that all stroke patients:

- have a comprehensive assessment of their needs carried out by a specialist stroke consultant, stroke nurse and therapist within 24 hours

- are cared for on a hyper acute stroke unit before moving to an acute stroke unit to continue treatment and rehabilitation

- stay in a specialist stroke unit for at least 90% of their inpatient stay in hospital (initially in a hyper acute stroke unit and then in an acute stroke unit); rather than being cared for on a general ward

- receive better quality care, a more positive experience of care and better outcomes after a stroke (i.e. fewer deaths and less disability from stroke).

We also want to offer access to TIA clinics 7 days a week for higher risk patients.

To deliver the care people need now and in the future, we must make sure that stroke services meet national quality standards, and are sustainable for the long-term based on the staff and resources we have.

Whilst not part of this specific consultation, we also need to do all we can to help people reduce their risk of having a stroke in the first place. In addition to the plans in this consultation we have a dedicated programme of work focussed on improving stroke prevention in Kent and Medway. You can find out more about this on our website at www.kentandmedway.nhs.uk/stroke.

Investing in urgent stroke services

The options set out here would all require additional up-front (or capital) investment from NHS England, of between £30-40 million to implement. The investment needed for implementing each option is set out on within section 6 of this document. The changes are not driven by the need to save money, but we do want to be sure we are getting the best value for the money spent on stroke services. From the time the changes were made, the better outcomes for patients would also mean a reduction in the overall cost of stroke services. The reduction would be mainly due to better recovery for patients who wouldn't then need as much long-term care.

5. What’s happened so far with our stroke review

Clinically led review and options development

The development and evaluation of our proposals has been clinically led throughout the review process, with recommendations coming from leading doctors and other health and care professionals in Kent and Medway, and further tested with a panel of senior clinicians from across the south east of England. You can find out who the members of these clinical groups and boards are on our website www.kentandmedway.nhs.uk/stroke.

Our **Stroke Clinical Reference Group** was established in January 2015.

It has an independent clinical chair and its clinical members are from hospital trusts in Kent and Medway and the ambulance service. It also has patient representatives.

The **Kent and Medway Clinical and Professional Board** members are senior clinical leaders from across Kent and Medway, members include NHS Trust medical directors, clinical commissioning group clinical chairs (who are also local GPs), directors of public health and nursing representatives.

The **South East Coast Clinical Senate** brings together a range of health and social care professionals, with patients, to take an overview of health and healthcare for local populations. It provides a source of independent, strategic advice and guidance to healthcare commissioners and other stakeholders to help them to make the best decisions about healthcare for the populations they represent.

The **National Clinical Director for Stroke**, Professor Tony Rudd has provided clinical oversight, challenge, expert clinical opinion and learning from other stroke reviews.

More information on how we have made sure the stroke review programme has been fair, robust and good quality, is set out in the pre-consultation business case which is available on our website. Two reports from the South East Coast Clinical Senate, on our case for change and our options, are also available on the website www.kentandmedway.nhs.uk/stroke.

Stakeholder engagement

Since late 2014, local health commissioners have been talking to the public and clinicians across Kent and Medway and neighbouring areas of Sussex, Surrey and south-east London about acute stroke services with a view to reorganising services to improve clinical outcomes for patients.

Stroke survivors, their families and carers, and members of the public have played a key part in shaping potential future models of care. Varied, robust and in-depth engagement has taken place with stroke specialists, clinical staff, voluntary organisations, stroke survivors, families, carers and the public to gather people's views and insight. This has included surveys, focus groups, listening events, clinical engagement events, roadshows, face-to-face meetings, and information provided through newsletters, printed magazines, media, and social media.

In November and December 2015 we held three 'People's Panels' which looked in detail at the case for change. They questioned and challenged the

emerging proposals for improving future stroke care and voted on different aspects of stroke services – establishing what they, as patients and carers, value most.

In March 2016 we ran a challenge session with national leads and patient and public representatives to test the work to date and the emerging options. In September and October 2016, there was a further series of events involving people who have had a stroke, their carers, and members of the public.

In 2017, listening events were held in every clinical commissioning group area in Kent and Medway, and during the summer we engaged with staff, stakeholders and the public around the case for change and the evaluation criteria to use for shortlisting potential site options.

A detailed list of stakeholder engagement activity to date is available on our website at www.kentandmedway.nhs.uk/stroke.

We will be holding more events as part of this consultation and we have a range of other ways for you to give your views, see section 7 for details.

Getting to the shortlist of potential site options for consultation

We have followed a detailed process to look at potential options for the future of hospital-based urgent stroke services. The process has been led by stroke specialists from across Kent and Medway, including consultants, doctors, nurses and other healthcare professionals. We have worked with patient and public groups, and their representatives throughout the development of the options.

In summary we have used a multi-step process of filtering out potential options by applying different types of agreed criteria. This allowed us to move from a long list that considered all possible options with different numbers of hyper acute stroke units, to a medium list of possible 3-site options, and then down to the shortlist of 3-site options which form part of this consultation.

A summary of the evaluation criteria used is at the back of this document, and a detailed document with the full evaluation process is available on the consultation web pages at www.kentandmedway.nhs.uk/stroke.

6. Our proposals for stroke services

The proposed changes for Kent and Medway

Our proposal is to establish 3 hyper acute stroke units operating 24 hours a day, 7 days a week, to care for all stroke patients across Kent and Medway. We would also locate acute stroke units alongside each of these hyper acute units, where people may go after the initial 72 hours for further care until they are ready to be discharged, as well as transient ischaemic attack (TIA) clinics.

This means we would stop providing urgent stroke services from hospitals that are not identified as locations for the hyper acute stroke units. We are exploring if some TIA clinics could continue to run at some local hospitals. This would allow access to specialist assessment closer to home; with staff at hyper acute stroke units always contactable for support or admission if needed.

This proposal is based on the work carried out over the past 3 years (since late 2014) looking at the best practice guidelines and standards and our population and the incidence of stroke in Kent and Medway (now and predicted in the future).

We are consulting on the proposal to establish hyper acute stroke units; whether 3 is the right number; and 5 potential options for their location.

Proposed options for locations of hyper acute stroke units:

Option A - Darent Valley Hospital, Medway Maritime Hospital, and William Harvey Hospital.

Option B - Darent Valley Hospital, Maidstone Hospital, and William Harvey Hospital.

Option C - Maidstone Hospital, Medway Maritime Hospital, and William Harvey Hospital.

Option D - Tunbridge Wells Hospital, Medway Maritime Hospital, and William Harvey Hospital.

Option E - Darent Valley Hospital, Tunbridge Wells Hospital and William Harvey Hospital.

The order is not a ranking and we are not identifying a preferred option until we have fully and carefully considered all the evidence and data available to us, including the views and feedback gathered via this public consultation.

Getting your views on our proposals

We have proposed these options after careful and detailed consideration of a wide range of evidence, information and views. We are now formally consulting to find out what you think about our proposals for making changes to hospital-based urgent stroke services.

An independent research company has helped us develop the consultation questions. And an independent research company will collate all the responses we receive from local people, staff and other stakeholders. You can see the questions and find out about the different ways you can respond to this consultation at the end of this document.

The consultation process is not a referendum. We are not asking you to vote for your preferred option. Rather, we want to know what you think about the impact the options would have on urgent stroke care, whether you think they are likely to improve the quality of care and improve access to services for you and your family. We want to know if you think we have missed any important information or evidence in our development of these proposals and options that could impact on the final decision about how to organise these services across Kent and Medway in the future.

Over the next few pages we explain more about what the proposed changes might mean for you, and what the benefits and potential disadvantages of the different options are. Some of the benefits and potential disadvantages are the same for all the options and some are different between the options. Some of the options might affect you more than others. We would welcome your

comments on all the options or other options you think we should consider. You can see a detailed evaluation document on our website www.kentandmedway.nhs.uk/stroke which shows the other possible combinations of 3 sites that were considered but were less favourable.

What are the benefits of the proposed changes?

The evidence tells us that changing how stroke services are organised across Kent and Medway would bring important benefits for people who have a stroke. Patients who are taken to, and treated in, a hyper acute stroke unit immediately after their stroke have a better chance of surviving and having less long-term disability; compared to patients taken to a hospital without a specialist unit working 24 hours a day, seven days a week.

If we make the proposed changes to stroke services, there would be benefits for both stroke patients and the staff working hard to deliver the best possible care.

The main benefits of the proposals would be:

- All stroke patients across Kent and Medway receiving consistently high quality care regardless of where they live or when their stroke occurs (i.e. reducing the variable quality of care currently provided).

- More patients getting brain scans and, if needed, clot busting drugs within the recommended time.

- A reduction in deaths from stroke.

- Fewer people living with long-term disability following a stroke.

- Fewer people losing their independence and being admitted to nursing/care homes following a stroke.

- Shorter stays in hospital.

- Clinics for transient ischaemic attacks (TIA) or “mini strokes” would be consistently available 7 days a week.

- Improved experiences for patients and their family, friends and carers from being treated in a specialist unit with services available 24 hours a day, 7 days a week.

- Improved experiences for staff from improvements in patient care, improved team and multi-disciplinary working, and increased opportunities to maintain and build their specialist skills.

An illustrative patient story

Bill who experiences a thrombotic stroke (blood clot)

Bill, a 63 year old man, is at home watching TV on a Friday night when around 9pm he realises that his face has become lop-sided and he cannot lift his right arm. He recognises the signs of a stroke from the FAST adverts (Facial drooping, Arm weakness, Speech difficulties, Time) and calls 999 immediately.

Care in an under-performing stroke service:

Paramedics arrive and take Bill to the nearest A&E. It is a busy night in A&E and although he is assessed and cared for, there is a delay in getting a CT brain scan. He has the scan over an hour after reaching A&E which when reported confirms that he has a blood clot in an artery in the brain. By this time it is too late for clot busting treatment. Bill is moved onto the local stroke ward. There are no therapists or stroke consultants available to see him over the weekend on the stroke ward. His swallowing becomes more difficult and he develops a chest infection.

He spends three weeks in hospital due to the infection. Despite rehabilitation Bill continues to have difficulty swallowing forcing him to radically change his diet. He also never regains good control of his arm which makes everyday tasks much harder and eventually prompts a move into a care home.

Care in a best practice stroke service:

The paramedics assess Bill and explain they are taking him straight to a specialist stroke unit. It’s further away than the local hospital but he’ll get specialist care faster. The stroke unit is alerted by the paramedics and a team gets ready for his arrival.

When Bill arrives he is met by the stroke team. He is assessed quickly and taken straight in for a brain scan, which confirms a blood clot. After explaining the problem to Bill, and the risks involved in the treatment, the stroke consultant gives him an injection to dissolve the blood clot. This all takes place within 2 hours of him calling 999.

He is then moved onto the hyper acute stroke unit. He rapidly starts feeling better and regains some function of his right arm, though his speech is still slurred. He is admitted for observations and further assessments by a multidisciplinary team, including speech and language therapists who recommend a thickened diet initially. A stroke consultant sees him on the ward on Saturday, explains what happened, the likely cause of the stroke, what the future holds for him, and starts secondary preventative medicines after a repeat scan that evening. His rehabilitation starts on Sunday morning with occupational, speech and language and physiotherapy sessions.

On Monday afternoon Bill is well enough to transfer to the Acute Stroke Unit. He continues to make good progress and is confirmed fit to go home on Wednesday. He has stroke specific rehabilitation sessions planned at home as part of being discharged.

Potential disadvantages and concerns

During our review of stroke services, we have considered the potential disadvantages of making changes and we have actively listened to the questions and concerns raised through our engagement with patients, staff and other stakeholders.

We firmly believe the evidence shows that creating hyper acute stroke units in Kent and Medway would benefit patients, specialist stroke staff and the wider NHS and social care system; and we believe the benefits outweigh the disadvantages.

An integrated impact assessment has been carried out on the proposals as part of the pre-consultation business case. The report covers impacts on equality, health, travel and access, and sustainability. It is available at www.kentandmedway.nhs.uk/stroke.

Whether 3 units is the right number?

We looked carefully at how many hyper acute stroke units we believe we need in Kent and Medway before proposing 3 as the optimal number. In summary, by consolidating specialist staff, our equipment and other resources into 3 hyper acute stroke units we can provide care in line with the standards that all patients should be able to expect, and staff want to provide whilst still making these services accessible in terms of travel times.

We do not have the staff or resources to create hyper acute stroke units at all hospitals. We believe that having more than 3 hyper acute stroke units would spread our staff and patients too thinly to make the service safe, sustainable and to allow the delivery of high quality care.

Stroke specialists, and other stakeholders, including patients and the public, have broadly agreed that the option of 2 hyper acute stroke units should be excluded. This was because 3 units would make the system more resilient – for example to help manage peaks in demand, or in the event that 1 unit was not usable due to damage e.g. fire – as well as offering good access to patients.

Therefore, our stroke specialists are proposing that there should be 3 hyper acute stroke units in Kent and Medway.

The location of acute stroke units, for care after the initial 72-hours following a stroke

Some concerns have been raised about having the acute stroke units on the same sites as the hyper acute units; with views expressed that locating them at other hospitals would allow for more local care after an initial 72 hours on a hyper acute stroke unit. It is possible to have separate hyper acute stroke units and acute stroke units on different hospital sites. However, a similar workforce is needed to cover each type of unit and therefore separating them would involve additional workforce pressures. Locating both types of unit in the same place also significantly reduces the need to transfer patients. Clinicians therefore agreed that hyper acute stroke units and acute stroke units should be together on the same sites in Kent and Medway.

Travel times

We know how important it is to you that services are easy to access for you and your family. Depending on where you live, the ambulance journey to reach a hyper acute stroke unit may be longer than being taken to your nearest A&E, but what is most important is the speed and quality of specialist care you receive once you reach the hyper acute unit.

A shorter journey to a hospital without a hyper acute stroke unit can be worse for stroke patients than a longer journey to a hyper acute stroke unit. The evidence, from elsewhere in the country where similar changes have already been made, shows that patients who are treated in a hyper acute stroke unit have better outcomes because they get a faster diagnosis and specialist

treatment, even if the initial ambulance journey is longer. It is also important to remember that ambulance paramedics are skilled clinicians who begin assessment as soon as they arrive and provide care throughout the journey. The ambulance service's call handlers are also an essential part of identifying potential strokes and ensuring patients are taken to the most appropriate hospital and receive a quick response when they arrive.

In the view of our stroke specialists, the benefits to all stroke patients of being treated at a hyper acute stroke unit outweigh the potential disadvantages of some patients facing longer travel times.

National standards say that patients should get clot-busting drugs, if they need them, as early as possible but ideally within 2 hours of calling for an ambulance. Therefore, we considered that an hour was the maximum acceptable journey time by ambulance, to allow enough time once a patient gets to a hyper acute stroke unit to have a scan and be given clot busting drugs if needed. Between 10 and 20 per cent of stroke patients may need clot busting therapy.

All 5 of the consultation options mean that 98 per cent of people could reach a hyper acute stroke unit by ambulance within an hour; and only a few minutes over 1 hour for the remaining 2 per cent. For all the options, over 90 per cent of people can reach a hyper acute stroke unit within 45 minutes by both ambulance and car.

Around 75 per cent of people can reach a hyper acute stroke unit within 30 minutes by both ambulance and car. In developing our shortlist of potential options, we rated the options with the shortest journey times for the most

people more positively. The tables on pages 29-33 show the percentage of people who can reach each hyper acute stroke unit within 30 minutes and 45 minutes by both ambulance and car for each of the 5 shortlisted options.

When someone has a stroke, an ambulance should always be called. There is no circumstance where stroke victims should be driven to a hospital by car or taken to hospital on public transport. However, if a family member, friend or someone you care for has a stroke, you may need to travel further to visit them. We know that for people who rely on public transport this may be a particular area of concern. We believe the benefits of reducing deaths and long-term disability caused by strokes outweighs the short-term inconvenience for people visiting stroke patients in hospital.

Why some hospitals are not included in any of the options

At different stages of the evaluation process we excluded some of the hospitals in Kent and Medway because they did not meet the required criteria. The Queen Elizabeth the Queen Mother and the Kent & Canterbury hospitals have been excluded from all the shortlisted options.

Both hospitals are run by the East Kent Hospitals University NHS Foundation Trust; who also run the William Harvey Hospital. We have worked closely with the Trust to look at each site's potential to be a hyper acute stroke unit:

Kent & Canterbury Hospital – does not currently provide a stroke service or the range of other emergency and urgent care services that are needed to support a hyper acute stroke unit. This meant it did not pass the 2nd stage of our evaluation process.

Queen Elizabeth the Queen Mother Hospital – does have the emergency and urgent care services needed to support a hyper acute stroke unit, but does not have a range of other services that are desirable to have alongside a hyper acute stroke unit. This meant that while it was included in our medium list; it was evaluated less favourably than the William Harvey which has both the needed and desirable services.

We also asked the Trust whether it could develop 2 hyper acute stroke units. They concluded that it would be very difficult to attract enough specialist stroke staff to run 2 units; so options including both the Queen Elizabeth the Queen Mother and William Harvey sites were evaluated more poorly and did not make the shortlist that is part of this consultation.

There is a separate review of the possible options for the future location of emergency care and specialist services in east Kent. It would be wrong to wait for this work to be completed because this would slow down the essential decisions we need to make on stroke services. If, following the east Kent review, the William Harvey Hospital was no longer a long-term option for emergency and specialist services and these moved elsewhere – then we would anticipate any hyper acute stroke service would also move with them, subject to consultation.

Recruitment and retention of stroke staff

We know from staff feedback that specialist stroke staff generally support the development of hyper acute stroke units to improve the quality of care for patients. At the moment we face significant vacancies in the stroke services at

all 6 current sites. We believe setting up 3 hyper acute stroke units would improve recruitment and retention in the medium to long term, however, there may be short term disadvantages.

The changes would mean that some existing staff would be asked to change where and how they work. For some staff this would mean longer travel times to work, different shift patterns, working with different people and in a different environment.

For some staff the impact of these changes on work and home life may not be acceptable and we may be at risk of losing some of our talented and dedicated stroke staff. Trusts would work through their HR processes with individual staff to support them in any changes and to provide individual solutions wherever possible. If changes were unsuitable for individuals, we expect that most could be offered alternative roles allowing them to stay on the same site.

During the development of the potential options stroke survivors, local people and staff consistently expressed concerns about the number of staff needed to establish hyper acute stroke units in Kent and Medway. There is a national shortage of stroke consultants and specialist stroke nurses and therapists. All options would mean recruiting additional consultants and we evaluated options which require the fewest extra consultants more highly.

We would deliver a detailed staff development and recruitment plan as part of setting up hyper acute stroke units. We know that other hospitals around the country with hyper acute stroke units find it easier to recruit stroke consultants and other specialist stroke staff because they offer better opportunities for

professional development, and allow staff to care for patients in line with national best practice.

Potential loss of other services at hospitals without a hyper acute stroke unit

Part of our evaluation process looked at what ‘co-dependent’ services are needed for a hyper acute stroke unit. Co-dependent services are other hospital departments that are essential to the safe and effective treatment of, in this case, stroke patients. Some of the co-dependent services that need to be on the same hospital site as a hyper acute stroke unit include emergency care and acute medicine, critical care units, x-ray, CT and MRI scanning, occupational therapy and physiotherapy.

There are also some specialist services that it is beneficial to have on the same site as a hyper acute stroke unit, for example a trauma unit, vascular surgery (surgery carried out on blood vessels) and interventional radiology (to support developing mechanical thrombectomy). When we evaluated the potential options, we rated hospitals which have these beneficial services more highly than those without.

During the development of the options, some staff and local people have expressed concern that if a hospital does not have a hyper acute stroke unit it may be at risk of losing other specialist services, or not being considered for the development of these services in the future. Although hyper acute stroke units are dependent on other services such as emergency medicine and A&E, we are not proposing any changes to these services at sites which do not

develop a hyper acute stroke unit. These services are also not dependent on a hyper acute stroke unit being at the hospital.

The impact on hospitals outside Kent and Medway

Some options would mean more patients would go to a hyper acute stroke unit outside of Kent and Medway. This would put additional pressure on those hospitals, in terms of needing to recruit additional staff, add more beds and other resources.

During the evaluation process we ruled out any potential option that would need hyper acute stroke units outside our area to add 20 beds or more. We have considered the impact of the options on workforce and estates (buildings) at other hospitals, and factored in capital costs required to put more beds in stroke units outside Kent and Medway.

Conversely, options including a hyper acute stroke unit at Darent Valley Hospital would make it the closest unit for some Kent and Medway residents who would currently be treated at the Princess Royal University Hospital (PRUH) in Orpington. This would reduce the number of hyper acute stroke beds needed in the future at the Princess Royal Hospital. There has already been substantial discussions with the Princess Royal University Hospital who have given their support to the proposals.

Further discussion with the Princess Royal Hospital, Eastbourne District General Hospital and any other affected hospitals and commissioners outside of Kent and Medway will continue through this consultation process.

Summary of location options

The following pages outline each of the 5 options for locating hyper acute stroke units at 3 sites in Kent and Medway. There is more detailed information on each option in the pre-consultation business case on our website www.kentandmedway.nhs.uk/stroke.

The options are not ranked in order of preference. We want to hear your views on all five options.

Notes on all options:

Travel times – all options allow 98% of the population to reach a hyper acute stroke unit within 60 minutes, therefore we have shown the percentage of population within 45 and 30 minutes of a hyper acute stroke unit to allow clearer differentiation between the options.

Capital costs – this shows the total investment in building/refurbishment and new equipment that would be needed across all sites in the option, including where relevant, for hospitals outside of Kent and Medway.

Net Present Value – this is a calculation to show the overall financial benefit over the next 10 years for each option. It compares the total investment (including upfront capital investment, one-off transition costs, workforce and other service costs) against total potential benefits (including savings as a result of reducing long-term complications and disabilities through the new

model, and the net change to service costs). A higher value shows a greater benefit.

Hospitals outside Kent and Medway – where options show bed numbers and strokes treated these only relate to Kent and Medway residents. It is not the total size of those stroke services.

Option A - Darent Valley, Medway, and William Harvey

Quality of care

Each site was assessed against 3 issues and given a positive, neutral of negative evaluation.

Beneficial services on site: Darent Valley (neutral), Medway (positive), William Harvey (positive); overall assessment for all sites (positive).

Potential to offer mechanical thrombectomy: Darent Valley (neutral), Medway (positive), William Harvey (positive); overall assessment for all sites (positive).

Potential to be a major emergency centre: Darent Valley (positive), Medway (positive), William Harvey (very positive); overall assessment for all sites (very positive).

Travel times

73.4% of the population are within **30 minutes** of a hyper acute stroke unit when taken **by ambulance**.

91.0% of the population are within **45 minutes** of a hyper acute stroke unit when taken **by ambulance**.

71.9% of the population are within **30 minutes** of a hyper acute stroke unit when driving **by car at peak time**.

91.0% of the population are within **45 minutes** of a hyper acute stroke unit when driving **by car at peak time**.

Investment and workforce

The total capital investment needed is **£30.82million**

The net present value over 10 years is **£17.7million**

The number of additional consultants needed in Kent and Medway is **8**

The number of additional consultants needed outside Kent and Medway is **0**

Implementing the options

Total stroke beds needed: Darent Valley (32), Medway (30), William Harvey (53); Princess Royal in Orpington (8); Eastbourne (3); Brighton (1).

Extra stroke beds needed: Darent Valley (9), Medway (4), William Harvey (29); Princess Royal in Orpington (-2); Eastbourne (3); Brighton (1).

Additional strokes treated per year: Darent Valley (332), Medway (144), William Harvey (776); Princess Royal in Orpington (-24); Eastbourne (70); Other (28).

Building work or refurbishment needed: Darent Valley (refurbish existing wards), Medway (refurbish existing wards), William Harvey (build new stroke unit).

Option B - Darent Valley, Maidstone, and William Harvey

Quality of care

Each site was assessed against 3 issues and given a positive, neutral of negative evaluation.

Beneficial services on site: Darent Valley (neutral), Maidstone (neutral), William Harvey (positive); overall assessment for all sites (positive).

Potential to offer mechanical thrombectomy: Darent Valley (neutral), Maidstone (neutral), William Harvey (positive); overall assessment for all sites (positive).

Potential to be a major emergency centre: Darent Valley (positive), Maidstone (negative), William Harvey (very positive); overall assessment for all sites (positive).

Travel times

74.2% of the population are within **30 minutes** of a hyper acute stroke unit when taken **by ambulance**.

91.3% of the population are within **45 minutes** of a hyper acute stroke unit when taken **by ambulance**.

73.3% of the population are within **30 minutes** of a hyper acute stroke unit when driving **by car at peak time**.

91.6% of the population are within **45 minutes** of a hyper acute stroke unit when driving **by car at peak time**.

Investment and workforce

The total capital investment needed is **£36.29 million**.

The net present value over 10 years is **£12.1 million**.

The number of additional consultants needed in Kent and Medway is **8**.

The number of additional consultants needed outside Kent and Medway is **0**.

Implementing the options

Total stroke beds needed: Darent Valley (33), Maidstone (36), William Harvey (51); Princess Royal in Orpington (3); Eastbourne (3); Brighton (1).

Extra stroke beds needed: Darent Valley (10), Maidstone (24), William Harvey (27); Princess Royal in Orpington (-7); Eastbourne (3); Brighton (1).

Additional strokes treated per year: Darent Valley (369), Maidstone (517), William Harvey (733); Princess Royal in Orpington (-165); Eastbourne (12); Other (72).

Building work or refurbishment needed: Darent Valley (refurbish existing wards), Maidstone (build new stroke unit), William Harvey (build new stroke unit).

Option C - Maidstone, Medway, and William Harvey

Quality of care

Each site was assessed against 3 issues and given a positive, neutral of negative evaluation.

Beneficial services on site: Maidstone (neutral), Medway (positive), William Harvey (positive); overall assessment for all sites (positive).

Potential to offer mechanical thrombectomy: Maidstone (neutral), Medway (positive), William Harvey (positive); overall assessment for all sites (positive).

Potential to be a major emergency centre: Maidstone (negative), Medway (positive), William Harvey (very positive); overall assessment for all sites (positive).

Travel times

76.2% of the population are within **30 minutes** of a hyper acute stroke unit when taken **by ambulance**.

91.3% of the population are within **45 minutes** of a hyper acute stroke unit when taken **by ambulance**.

73.6% of the population are within **30 minutes** of a hyper acute stroke unit when driving **by car at peak time**.

91.6% of the population are within **45 minutes** of a hyper acute stroke unit when driving **by car at peak time**.

Investment and workforce

The total capital investment needed is **£37.86 million**.

The net present value over 10 years is **£14.4 million**.

The number of additional consultants needed in Kent and Medway is **8**.

The number of additional consultants needed outside Kent and Medway is **2**.

Implementing the options

Total stroke beds needed: Maidstone (21), Medway (27), William Harvey (50); Princess Royal in Orpington (25); Eastbourne (3); Brighton (1)

Extra stroke beds needed: Maidstone (9), Medway (1), William Harvey (26); Princess Royal in Orpington (15); Eastbourne (3); Brighton (1)

Additional strokes treated per year: Maidstone (139), Medway (87), William Harvey (723); Princess Royal in Orpington (358); Eastbourne (60); Other (45)

Building work or refurbishment needed: Maidstone (build new stroke unit), Medway (refurbish existing wards), William Harvey (build new stroke unit).

Option D – Medway, Tunbridge Wells, and William Harvey

Quality of care

Each site was assessed against 3 issues and given a positive, neutral of negative evaluation.

Beneficial services on site: Medway (positive), Tunbridge Wells (positive), William Harvey (positive); overall assessment for all sites (very positive).

Potential to offer mechanical thrombectomy: Medway (positive), Tunbridge Wells (positive), William Harvey (positive); overall assessment for all sites (very positive).

Potential to be a major emergency centre: Medway (positive), Tunbridge Wells (positive), William Harvey (very positive); overall assessment for all sites (very positive).

Travel times

82.2% of the population are within **30 minutes** of a hyper acute stroke unit when taken **by ambulance**.

92.0% of the population are within **45 minutes** of a hyper acute stroke unit when taken **by ambulance**.

79.8% of the population are within **30 minutes** of a hyper acute stroke unit when driving **by car at peak time**.

92.2% of the population are within **45 minutes** of a hyper acute stroke unit when driving **by car at peak time**.

Investment and workforce

The total capital investment needed is **£35.95 million**.

The net present value over 10 years is **£16.1 million**.

The number of additional consultants needed in Kent and Medway is **8**.

The number of additional consultants needed outside Kent and Medway is **2**.

Implementing the options

Total stroke beds needed: Medway (35), Tunbridge Wells (19), William Harvey (50); Princess Royal in Orpington (22); Other (1)

Extra stroke beds needed: Medway (9), Tunbridge Wells (5), William Harvey (26); Princess Royal in Orpington (12); Brighton (1)

Additional strokes treated per year: Medway (264), Tunbridge Wells (57), William Harvey (722); Princess Royal in Orpington (310); Other (21)

Building work or refurbishment needed: Medway (refurbish existing wards), Tunbridge Wells (build new stroke unit), William Harvey (build new stroke unit).

Option E Darent Valley, Tunbridge Wells, William Harvey

Quality of care

Each site was assessed against 3 issues and given a positive, neutral of negative evaluation.

Beneficial services on site: Darent Valley (neutral), Tunbridge Wells (positive), William Harvey (positive); overall assessment for all sites (positive).

Potential to offer mechanical thrombectomy: Darent Valley (neutral), Tunbridge Wells (positive), William Harvey (positive); overall assessment for all sites (positive).

Potential to be a major emergency centre: Darent Valley (positive), Tunbridge Wells (positive), William Harvey (very positive); overall assessment for all sites (very positive).

Travel times

76.9% of the population are within **30 minutes** of a hyper acute stroke unit when taken **by ambulance**.

91.9% of the population are within **45 minutes** of a hyper acute stroke unit when taken **by ambulance**.

76.4% of the population are within **30 minutes** of a hyper acute stroke unit when driving **by car at peak time**.

92.1% of the population are within **45 minutes** of a hyper acute stroke unit when driving **by car at peak time**.

Investment and workforce

The total capital investment needed is **£30.63 million**.

The net present value over 10 years is **£16.3million**.

The number of additional consultants needed in Kent and Medway is **8**.

The number of additional consultants needed outside Kent and Medway is **0**.

Implementing the options

Total stroke beds needed: Darent Valley (52), Tunbridge Wells (21), William Harvey (54); Princess Royal in Orpington (0); Other (0).

Extra stroke beds needed: Darent Valley (29), Tunbridge Wells (7), William Harvey (30); Princess Royal in Orpington (-10); Other (0).

Additional strokes treated per year: Darent Valley (802), Tunbridge Wells (89), William Harvey (828); Princess Royal in Orpington (-21); Other (0).

Building work or refurbishment needed: Darent Valley (refurbish existing wards), Tunbridge Wells (build new stroke unit), William Harvey (build new stroke unit).

7. Giving your views

We want to know what you think about these proposals and the potential options for delivering them before we make any decisions about the future of stroke services and how we organise them across Kent and Medway. Our consultation runs from 2 February 2018 and you can share your views with us until midnight on 13 April 2018.

Read more about the proposed changes

Visit the stroke consultation webpages at www.kentandmedway.nhs.uk/stroke where you will find all the detailed technical documents which support this consultation as well as a link to the online survey asking for your views on our proposed changes. If you do not have access to the internet and want additional information please contact us using the contact details below.

Come and talk to us

We are organising a series of public discussion meetings, as well as roadshow events to provide a drop-in environment where you can learn more, speak to the programme's clinical leaders and let us know what you think. To find out more about events near you please visit our website or contact us using the details below.

Invite us to speak with your group

We will be getting out and about talking to local communities and want to attend as many interested community groups e.g. stroke support groups, patient reference groups, disability alliances, as possible. Please get in touch so that this can be arranged, using the contact details below.

Send us your feedback

Online survey – you can complete the online survey at **www.kentandmedway.nhs.uk/stroke**

Postal survey – tear off the survey at the back of this booklet, complete by hand and post free to: **FREEPOST KENT AND MEDWAY NHS**

Email – There is space on the survey for any additional views, but you can also email us at **km.stroke@nhs.net**

Phone – call us on **0300 7906796**.

If you or someone you know needs this document in another language or format please contact us at **km.stroke@nhs.net**.

8. Next steps

When the consultation closes on 13 April 2018, all the feedback will be analysed by an independent research organisation. A report will be produced to be considered fully by the clinical commissioning groups.

We will publish this report on our website and make sure that people know when it is available. The report will cover:

- major themes from the consultation
- a summary of the responses about the proposals
- an overview of the process
- an explanation of how the final decisions will be taken (including dates of meetings in public) and a timeline for implementation if agreed
- how clinical commissioning groups intend to address any comments and concerns that people raise.

The Joint Committee of the clinical commissioning groups will meet in public to report back on the consultation, consider all the evidence in full and make a decision about the future shape of acute stroke services in Kent and Medway. It is expected that this public meeting will take place in the autumn. Details will be made available on our website at **www.kentandmedway.nhs.uk/stroke**.

To be kept informed about progress please visit the website to sign up to our newsletter.

9. Appendix A: Options evaluation process

How have we developed the options?

We have followed a detailed process to look at options for the future of stroke services. The process has been led by stroke specialists from Kent and Medway, including doctors, nurses, therapists and other healthcare professionals. We have worked with patient and public groups, and their representatives throughout the development of the proposals.

In summary we have used a three-stage process. At different stages of the process we have filtered out potential options by applying either fixed point, hurdle or evaluation criteria.

Fixed point criteria

If we considered every possible option for making changes to services, the list would be so long it would not be manageable. We used fixed point criteria to help us develop a realistic long list of options.

The fixed point criteria we considered was whether we would need to build a new hyper acute stroke unit on a green field site, or on an existing hospital site that does not currently have other urgent care services.

The stroke specialists decided that this was not a viable option because:

- It would take too long: we need to make improvements as quickly as possible

- We would be unlikely to get sufficient funding

- The essential ‘co-dependent’ services needed to run a hyper acute stroke unit would not be in place on either a new site, or an existing hospital site that does not have other urgent care services.

After applying the fixed point criteria our list of possible options for sites where 3 hyper acute stroke units could be located in Kent and Medway was all combinations of the 6 sites currently providing general stroke services and urgent care services, plus Kent & Canterbury Hospital where services have been temporarily withdrawn.

Hurdle criteria

The next stage of the options appraisal process was to apply the hurdle criteria to the potential options. They are called hurdle criteria because each long list option had to pass every hurdle successfully to be considered for the shortlist. If the option being considered ‘fell’ at any hurdle, it was excluded.

The hurdle criteria were developed by stroke specialists and NHS leaders, in consultation with patients and the public. The table below shows the hurdle criteria we applied to the long list of options.

Is the option clinically sustainable?

- How many hyper acute stroke units are clinically sustainable?
- Will the workforce be available to deliver the option?
- Do we have the necessary co-dependent services available to deliver the required standards of care?
- Will there be enough patients to ensure stroke staff maintain their skills and competency?

Is the option implementable?

- Can we put the option in to practice by 2020/21 in a way that ensures services are stable and sustainable?
- Will it negatively impact on any other services across the system to the extent that they can't function effectively?

Is the option a strategic fit?

- Is the option in line with existing commitments or decisions made as part of previous consultations?

- Would the option challenge or unpick past decisions about how services are organised, or about which services should be available on which sites across Kent and Medway?

Is the option accessible?

- Can 95% of patients reach a hyper acute stroke unit within 60 minutes at peak travel time?

Is the option financially viable?

- Does the option cost the same or less than the current forecast costs of doing nothing to change services?

Evaluation criteria

At the end of the hurdle criteria process, we had a list of 13 different 3-site options to consider in more detail. We used evaluation criteria to weigh up the pros and cons of each of the options. Unlike hurdle criteria, evaluation criteria do not typically have yes or no answers.

The evaluation criteria were developed by stroke specialists in partnership with patients and their representatives, the public and other stakeholders. Draft evaluation criteria were developed and then tested in July and August 2017 in a range of ways.

We held meetings, carried out surveys and ran focus groups to get views on the order of importance of the evaluation criteria. The final list of evaluation criteria we used is shown below in the order of the importance identified by stakeholders:

Quality of care for all

- Does the option provide improved delivery against clinical and NHS constitutional standards, and access to skilled staff and specialist equipment?

Access to care for all

- Does the option keep to a minimum the increase in the total time it takes people to get to hospital by ambulance and car (at peak times)?

Workforce

- Is the option likely to be sustainable from a workforce perspective, facilitating 7 day working and taking into account recruitment challenges and changes in what the workforce does?

- Would it be more difficult to recruit and retain staff with this option?

Ability to Deliver

- How easy will it be to deliver change within 5 years?
- How able/willing to deliver are the Trusts in question for each option?

Affordability and value for money

- Which options will give the best financial benefit over the next 10 years? (assessed using net present value)

We applied each of the evaluation criteria to the remaining 13 options. Options were either positive, negative or neutral against each of the criteria. The results for each option were reviewed and used to develop the final list of five options to be put forward for consultation. There is a detailed document showing how each of the 13 options was rated against the evaluation criteria on our website at www.kentandmedway.nhs.uk/stroke.

10. Our questions to you

The consultation questionnaire can be completed online at www.kentandmedway.nhs.uk/stroke or there is a plain text copy also on the website that you can complete and return to FREEPOST KENT AND MEDWAY NHS or email to km.stroke@nhs.net

Ends